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ABSTRACT

This proceedings of the first international conference on Acquired Immune Deficiency Syndrome (AIDS) and homeless youth included over 125 delegates from 32 countries. There was strong consensus among delegates that street youth are often in high and multiple Human Immunodeficiency Virus (HIV) risk situations, and programmatic responses are needed. Discussions addressed associated issues including violence towards street youth in both developed and developing countries. Delegates identified successful strategies and techniques for addressing the problems of these youth, and established relationships for future collaborative efforts. The worth, resiliency, and potentiality of these youth regardless of their race, economic status, place of residence, sexual orientation, or lifestyle underscored the discussions. The central consensus recommendation was that youth deserve protection from all forms of neglect, exploitation, and cruelty. Increases in violence against street youth reflect larger complex, often insidious economic, political, and social factors. Delegates described how endemic discrimination against street youth is exacerbated when youth are identified as being HIV positive or having AIDS. The second International Conference on Street Youth will be held as a satellite of the 20th International Congress of Pediatrics in Rio de Janeiro, Brazil on September 4th and 5th, 1992. This gathering will include street youth speaking on their own behalf about their interests and needs. General discussions will focus on primary health care and on decreasing abuse, violence, and killings of street youth. (LLL)

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PROCEEDINGS OF THE FIRST INTERNATIONAL CONFERENCE ON AIDS AND HOMELESS YOUTH: AN AGENDA FOR THE FUTURE

INTRODUCTION

G. Cajetan Luna, Conference Chairman; Research Associate, Mount Zion Hospital of the University of California, San Francisco.

The First International Conference on AIDS and Homeless Youth was held on June 25, 1990 at the University of California San Francisco. Over 125 delegates from 32 countries were in attendance. There was strong consensus among delegates that street youth are often in high and multiple HIV risk situations, and programmatic responses are needed. Discussions were timely and focused not only on the critical issue of AIDS, but also addressed associated issues including violence towards street youth in both developed and developing countries. In work groups, clinicians, educators, researchers, policy makers, and others had the opportunity to exchange and synthesize information regarding current data and programs being implemented for street youth.

Delegates also identified successful strategies and techniques for addressing the problems of these youth, and established relationships for future collaborative efforts. The worth, resiliency, and potentiality of these youth regardless of their race, economic status, place of residence, sexual orientation, or lifestyle underscored the discussions. The central consensus recommendation that was that youth deserve protection from all forms of neglect, exploitation, and cruelty.

It was clear from discussions that increases in violence against street youth reflect larger complex, often insidious economic, political, and social factors. Delegates described how endemic discrimination against street youth exacerbates when youth are identified as being HIV positive or having AIDS.

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A follow up meeting was also deemed necessary. As a result, the Second International Conference on Street Youth will be held as a satellite of the XXth International Congress of Pediatrics in Rio de Janeiro, Brazil on September 4th and 5th, 1992. The 1992 gathering will include street youth speaking on their own behalf about their interests and needs. General discussions will focus on primary health care and on decreasing abuse, violence, and killings of street youth.

In the meantime, Clinical, Policy, Research, and Social/Educational Agendas were developed at the 1990 Conference to provide recommendations for work in these areas with street youth and AIDS.

Similar issues were discussed in the four work groups, and the Agendas developed demonstrate like and diverse thoughts and opinions. They also illustrate consensus on the need for continued collaborative, international, multi-disciplinary efforts to face the existing and related challenges. Richard C. Brown, Della M. Hughes, Felicia Knaul, Mary Jane Rotheram-Borus and Peter Dalglish were kind enough to prepare the summaries of the discussions which follow.

FIRST INTERNATIONAL INVITATIONAL CONFERENCE

ON AIDS AND HOMELESS YOUTH

The Clinical Agenda

Prepared by Richard C. Brown, M.D., President of the Society of Adolescent Medicine; Clinical Professor, University of California, San Francisco.

The charge of this work group was to address clinical issues and questions regarding prevention, intervention and treatment of street youth and their high risk situations, particularly HIV.

Categories for discussion were terminology, access to clinical care, HIV testing and counseling, clinical care of HIV positive and negative youth and care and support of homeless youth who are ill and dying.

I. Terminology

There was considerable elaboration on the definition of homeless versus street youth. There was recognition of a range of categories which can be summarized as follows:

Terms	Concept
Work on the street	Youth working on the streets, with daily family contact
Youth <u>on</u> the street	Youth spending much of the time on the streets with "regular family contact."
Youth <u>of</u> the street	Youth living on the streets with irregular or little family contact.
Homeless Youth	Youth who are totally abandoned and without any family support.
Youth in Institutions	Youth who are without family but who are institutionalized.

The five categories were defined to illustrate the range of situations and to indicate that youth may move "in and out" of the various categories over time.

The age definition of street youth made no clear lower limit but did define the upper limit from 18 to 20 years of age. Such terms as high risk youth and risk behavior were rejected by the group in favor of the terms high risk and/or multiple risk situations. There was a consensus that terms must not "lower" or stigmatize youth. Terms such as victim and exploited youth were felt to be appropriate at times.

The issue of sexual practice versus sexual identity was explored at length. For homeless and street youth, the two issues are quite separate. It was agreed that the two must be separately defined.

II. Access to Clinical Care

There was general recognition that access to clinical care is a problem for street youth. Barriers to care are often overwhelming and result in delayed care, inappropriate care or lack of care.

The qualities for adequate care should include:

1. Acceptable care with outreach work, multi-disciplinary staff.
2. Available care geographically and convenient, extended clinical hours.
3. Accountable care which maintains standards of the local medical community. Standards of quality control should be maintained.

Every effort should be made to have good outreach and community agency involvement. the health care should be global as well as HIV 1 STD specific (see Clinical Care V).

Efforts should be made to expand and support existing AIDS program to also serve street youth.

The problem of health care funding and the need for advocacy is a universal problem. Innovative forms of preventative counseling were suggested which are more cost effective than individual counseling. Groups, video and other teaching methods were discussed.

Denial and marginalization of street youth demonstrated the need for creative advocacy in the community.There was consensus that advocacy should be employed for the empowerment and rights of street youth. Arguments should be presented which indicate "that investment in youth is investment in the future."

The AIDS epidemic can be used to "call attention" to a generalized lack of attention to street youth. When the basic health care needs of street youth are addressed, HIV prevention, counseling and care must be part of these broader needs.

III. Prevention

Special attention must be developed in the prevention of HIV infection as well as counseling in already infected street youth. There are often subpopulations of street youth who present various risk situations. The preventive counseling must be tailored to the individual subgroups. This should involve youth and persons working directly with youth.

Special attention should be targeted to youth at greater risk. Again, those youth should be involved in preventive efforts. Prevention should be empowering to youth and should be much more than "just condoms."

IV. HIV Testing and Counseling

Preparation for and carrying out testing must be done by skilled and trained counselors. The anxiety, fear and depression around the testing can put youth at higher risk.

There are times when an individual youth must be encouraged to refrain from testing until he or she is more stable and has a support person. All young people we are testing should have a trusted and supportive adult to carry them through the process.

Unlimited anonymous testing is valid for surveillance and as a guide for strategy planning. The youth must consent to all testing.

There was considerable concern expressed about the use and the disclosure of HIV study results. There is always potential that the results can stigmatize youth and increase their marginality. Statistics presented to scientific meetings versus to the media must be handled differently.

There was a consensus that all testing "should be in the individual child's interest." Basic requirements for testing are:

1). Appropriate and supportive pre- and post- test counseling.
2). Informed consent should be done for testing and disclosure.
3). Confidentiality must be ensured.
4). Follow up with a full range of services which are accessible and available.

V. Clinical Care for HIV Positive and Negative Youth

Much of the present knowledge regarding treatment is in the adult population. There is need for adolescent studies on therapeutic doses and protocols.

In many represented countries, medication treatment is minimal if not unavailable. Often, only psychological support is available to street youth. The contrasts between industrialized countries and developing countries is striking.

Good clinical care of AIDS patients is "global care" with a multidisciplinary team effort. There is a great need for funding support to pay health care providers to care for youth with AIDS. With improved funding, research can be developed on the epidemiology, ethnography and demography for street youth with AIDS.

In many countries, youth hostels and housing is badly needed. There is also a need for support and reward to the care givers who work with ill and dying youth with AIDS.

VI. Summary

The following summarizes the recommendations:

A. Terminology: It was recommended that terms be generated to indicate the great variety of circumstances of homeless/street youth. It was the consensus of the groups that the phrase used to describe this population be youth in "high risk or multiple risk situations."

   There was consensus that care be taken to differentiate sexual practice and sexual identity in street youth.

B. Access to Clinical Care: The following recommendations for qualities of care were:

   1. Acceptable care with outreach work and multi-disciplinary staff.

   2. Available care that is geographically convenient, with extended clinical hours.

   3. Accountable care which maintains standards of the medical community.

   It was recommended that creative funding and advocacy be developed. There was also consensus that advocacy be employed that empowers street youth.

C. Prevention: There was agreement that HIV prevention work be tailored to the specific subpopulations in need, especially in groups at greatest risk. Prevention should be empowering to youth.

D. HIV Testing and Counseling: There was consensus that HIV counseling and testing be done by skilled and trained counselors. A youth tested should have a trusted and supportive adult to carry them through the process.

There was general concern expressed regarding the use and disclosure of HIV testing and studies. There was consensus that all testing "should be in the individual child's interest."

The recommendations for testing were:

1. Appropriate and supportive pre- and post- test counseling.
2. Informed consent.
3. Confidentiality.
4. Follow up with a full range of clinical services.

E. Clinical Care for HIV Positive and Negative Youth: It was recommended that:

1. Research protocols be established for treatment of youth
2. That medication be made available to infected youth.
3. That the care of youth with AIDS be "global care."
4. That improved funding allow for clinical research and better care of youth with AIDS and/or HIV positive.
5. That there be greater support for health care givers to care for homeless youth and youth with AIDS.

FIRST INTERNATIONAL INVITATIONAL CONFERENCE

ON AIDS AND HOMELESS YOUTH

The Policy Agenda

Prepared by Felicia Knaul for Childhope and Della M. Hughes, Executive Director, National Network of Runaway and Youth Services, Inc., Washington, D.C.

Although the title of the Conference named homeless youth as the target population, the term is limiting and misleading. In fact, in many countries and urban areas the terms "street youth" or "street children" are more common. Clearly, it is important to be cognizant of who is being served, under what conditions and why, because these all affect the development and implementation of policy. Whatever definition is adopted should be non-stigmatizing and sensitive to the needs of sub-groups in the population, such as lesbian and gay youth. It should also reflect the root causes of homelessness or of street life for these young people.

I. General Discussion

A. What are the considerations in choosing a definition?

HIV infection is a stigmatizing disease, as is being a street youth. Descriptions and definitions of these youth should minimize the likelihood, in as much as is possible, of further stigmatization. Use of culturally sensitive language is one way of creating a less judgmental way of describing individuals and their circumstances.

The definition should be one that enables non-governmental organizations (NGOs) and governments to advocate for youths' rights and to prevent the marginalization of street youth and the agencies working with them.

At times the issue of street youth and AIDS should be considered in a larger context, to give organizations working with them a broader base from which to advocate and seek support. There are, however, times when it is more appropriate to be specific in addressing the more limited issue of street youth and AIDS and times when it may be best to not give any definition at all.

B. What components should be a part of the definition?

Street youth range in age from 0 to 21, since some children are born on the street. They are both male and female and of all racial and ethnic groups. The population is diverse and has been identified as child laborers, runaways, youth thrown out by their parents/society, lesbian and gay youth, AIDS orphans, HIV-infected youth, out-of-school youth, prostitutes, and children in especially difficult circumstances. Sometimes they are called "of the street" and sometimes "on the street." These statements are not interchangeable, each having a specific connotation.

These young people find themselves on the street because they have been rejected by parents and/or significant others for becoming pregnant or HIV-infected, being gay or lesbian, using or dealing drugs, or as a result of conflicts within the family. They may also be on the streets because they left home due to violence in the home, drug use by family members, fear of being discovered gay or lesbian or lack of a place they feel they can be "themselves." The family may be homeless or so poor that the children are working on the streets to supplement the household income. Lack of housing and disillusionment are other reasons why children go to the street.

Street youth may engage in sex for survival purposes, to get a meal or shelter or clothing. They also may exchange sex for money. We are reluctant to call this prostitution. This type of labeling only further victimizes these young people who are living in high risk situations because they have been previously abused. It also takes the focus away from the adults who exploit them.

II. Protecting the Rights of Street Youth

A. Specific Recommendations

Street youth have the right to informed consent and confidentiality in testing. They have the right not to be tested for AIDS and the right to know their test results, should they choose to be tested.

Guidelines regarding testing that emphasize the protection of youths' rights should be based on the models developed by Medicine de Monde or the Society for Adolescent Medicine. Examples of critical components of the guidelines include:

1. if testing is provided, then services must be provided concomitantly;
2. sharing of information about the youth should not be done without the youth's consent; and
3. clients should not be denied access to services or programs based on test results.

It is critical that research be conducted with and about street youth to better understand their circumstances and needs and to improve services. Yet, researchers should be aware of the potential impact of their studies on these young people. For example, there may not be adequate services in place to handle a youth receiving positive test results or the youth's life may be endangered if positive test results become known. Street youth are being killed by authorities and/or vigilante groups in Brazil and Colombia because they are suspected of being HIV positive.

Further attention should be devoted to determining how these rights can be enforced and by whom. There are existing mechanisms which should be used more effectively, but there is a clear need for stronger efforts on a national and multi-national basis.

Street youth, in fact children and youth in general, require specific, targeted services. Youth health workers must be educated on modes of transmission of the virus and basic facts about HIV and AIDS before being permitted to test young people. It is also important that they have a solid understanding of the circumstances in which street youth live and from which they have come and their developmental needs and issues.

Street youth have few, if any, rights in most countries. NGOs should advocate for the enactment of legislation where it does not exist and for the improvement or enforcement of existing legislation. The United Nations Convention on the Rights of the child has developed an excellent model declaration of youth rights. This statement should be endorsed and enacted into law and policy in all countries.

Some of the broader rights of youth that deserve special mention are:

1. the right to be a child;
2. the right to make choices;
3. the right to be heard; and
4. the right to free legal representation.

III. Prevention Policy

A. Specific Recommendations

1. Methodology

HIV and AIDS prevention should occur through all possible channels, including formal, informal and non-formal education.

Street youth should actively participate in developing the actual messages to be used. They have first-hand knowledge and experience, which makes them invaluable resources for determining what messages are successful.

Peer programs should be promoted and utilized as much as possible. HIV-infected youth can be among the most effective in educating other youth. Whenever they are employed as street health educators or in other roles, they should be adequately remunerated, trained and counseled.

Whenever possible, prevention efforts should be family- and community-based. Street youth may be the single most effective vehicle for educating their own family members about HIV and AIDS.

Developmental, gender, sexuality, sexual orientation, cultural, and religious issues are among a range of aspects of their lives and circumstances with which young people cope. Both methods and messages used in prevention efforts should take these into account to insure that youth feel and believe they are understood.

2. Materials

Prevention materials should be appropriate to the educational and developmental levels of street youth. They should also be adapted to acknowledge and encompass the daily strategies which these youth must employ in order to survive.

3. Message

While condom-based prevention is often appropriate, there is also a need to promote other messages for street youth, such as the value of practicing non-penetrative sex.

4. Related Issues

Drug and alcohol abuse prevention and treatment programs should be accelerated for street youth, since there has been proven to be a strong connection between drug use and HIV-infection. Recognizing that street youth are likely to find and use improperly disposed needles, the United States' Centers for Disease Control's precautions on disposal of needles should be promoted world-wide.

Prosecution and treatment of adults including service providers who exploit street youth is necessary to begin to break the cycle of victimization.

Improvements in medical technology will lengthen the lifetimes of HIV-positive youth. Hence, health care for these youth needs to be made a policy priority now.

5. Discussion

Effective prevention requires an integrated approach in which HIV and AIDS are dealt with in light of the fact these young people live in high risk situations and that they are for the most part minors. Lack of parental/guardian permission may be a barrier to health care, but HIV prevention efforts can serve as a means of linking youth with resources and for advocating for services to meet their needs.

IV. The Role of Donor Organizations

A. Specific Recommendations

Street youth are more likely to get responsive, effective services if donor and service delivery organizations work collaboratively. There are inherent tensions in the relationship between the two, but the possibility for developing more creative and sound programming exists if there is mutual respect. One means of establishing respect is having periodic meetings with representatives of both groups present in the context of a "donors forum."

Donor organizations at times set unrealistic goals for NGOs, not understanding the constraints under which the staff must work. The problems they are trying to address are complex and intertwined with issues much larger in scope than the specific needs of the target population alone.

Because the issues NGOs are attempting to address are a part of this larger context, they may be perceived by donor organizations as being ineffective or unable to produce quick solutions. The reality is that NGOs are typically the most effective in addressing local human needs in highly creative and responsive ways. They need time and support in order to develop their services and to translate these into marketable results. NGOs also need "venture capital" investments to facilitate the development of innovative approaches to working with street youth around the issue of AIDS.

NGOs need to be aware of the donor's need for accountability and that this can serve as a mechanism for quality control. In order to respond to the requirements of donors, NGOs need technical assistance in evaluation and reporting techniques.

Funds for this kind of institutional development should be included in project budgets over and above funds designated for programs.

In funding NGOs for providing services to street youth on the issue of AIDS, donors should select NGOs with demonstrated expertise in working with this population on a variety of issues. Obviously, this must be modified for areas never having had this type of service before or services provided by as questionable organization. NGOs that have "jumped on the bandwagon" to gain access to AIDS funding should be avoided if no previous track record with street youth exists.

Government should be a resource for NGOs. It is critical to find sympathetic individuals within government to maximize the potential of what government can offer to benefit street youth. Working with government also means working toward change if it is hostile or unresponsive. NGOs constitute a powerful lobby for change.

NGOs have never received sufficient recognition or financial assistance for their work with street youth in general, and more specifically, for needs related to AIDS and AIDs prevention. Too much funding is channelled through government and remains there rather than moving through the bureaucracy to direct service programs. It is critical, however, that the private sector join NGOs and the government in addressing these issues.

The link between researchers and NGOs deserves special attention, because NGOs need to incorporate factual information into their reports and proposals and develop programs based on research data. Yet, researchers should understand that direct service providers in NGOs may not be "scientists," but that their knowledge and expertise is credible. The methods for learning may differ, but the end result, if the two approaches are used in tandem, is improved services for street youth.

V. Mechanisms for Collaboration

A. Specific Recommendations

Individuals and organizations working with street youth need a mechanism for centralizing information and disseminating knowledge about funding, programs, techniques, new projects and research. Typically grassroots, locally-based efforts are isolated from resources, information and support that exist outside of the immediate area. There is a particular lack of information about who receives funding and what types of projects are funded.

One solution to this would be a newsletter in which individuals and organizations interested in street youth and AIDS could share information. The newsletter could be linked to the International Conference on AIDS and Homeless Youth.

An important role government should play is that of a broker of resources and information about the availability of funding. NGOs should collaborate, especially at the national level, to provide more integrated services and to attempt to address the needs of street youth from a holistic perspective. One way to accomplish this would be for NGOs to approach donors with collaborative proposals which incorporate the services of a variety of organizations.

Work with street youth has clear and evident political aspects. Local NGOs may need the assistance of advocates, such as Amnesty International, and powerful donors, such as the World Bank, to fight for the rights of young people. The issue of human rights is particularly serious given the violence and abuse that has emerged as a result of the prevalence of AIDs among street youth. Individuals working with these youth in some countries are in personal danger themselves. Some NGOs are experiencing expropriation of funds as a result of political and economic pressures. On their own, NGOs cannot protect themselves, but in collaboration with larger national, bilateral, and multilateral organizations they can improve the human rights situation and sustain their work with street youth.

VI. Model Programs

The following principles were agreed to be components of a model program:

--Community involvement is an effective way of enhancing the ability of an organization to sustain a program.

--Using street youth as peer educators improves the quality of the connection with other youth and the possibility for education to occur.

--The training of educators and service providers over long-term, practice-oriented internships is optimal.

--NGOs, governments and donors should share information and resources.

--The programs should be evaluated on an on-going basis using appropriate indicators such as: the prevalence of condom use, the rate of remission of STDs, dedication to the provision of integrated services, and the involvement of youth in information dissemination.

--The project for AIDS prevention must be integrated into a multi-service program that addresses the larger issues of street youth.

FIRST INTERNATIONAL INVITATIONAL CONFERENCE

ON AIDS AND HOMELESS YOUTH

The Research Agenda

Prepared by Mary Jane Rotheram-Borus, Ph.D., Director, the HIV Adolescent Studies Group; Associate Professor, Columbia University, New York City, New York.

The following issues were identified and recommendations were generated during the discussion of the research group:

I. Epidemiology

A. What is the epidemiology of HIV and street youth?

1. A basic epidemiological description of the numbers of street youth internationally, the distribution cross-nationally and cross-culturally, the means of survival, developmental patterns (age at first exposure and means of support across different ages), and sources of supportive services in each city and country are needed. In addition to epidemiological survey data, there is an important need for ethnographic descriptions of the populations.

2. A basic description of risk acts (sexual and substance abuse) and the contexts in which these acts occur is needed. For example, it will be critical to identify differential patterns of acculturative stress in families in rural versus urban settings.

B. How to reach and retain street youth in research projects and clinical services?

1. Street youth are often not included into traditional institutional networks for providing health care and social services. When they do contact such services, compliance with follow-up services are inconsistent. Thus, recruitment and retention in research protocols is likely to be a difficult problem. To recruit youth, the researcher's attitude must be considered, and the benefits for the youth participating in the research must be detailed.

II. HIV Testing

A. Should street youth be HIV tested?

1. The potential cost/benefit of anonymous and confidential testing needs to be examined. In particular among street youth, the importance of anticipating that high rates will lead to youth being stigmatized. In addition, the cost-benefit analysis depends on the availability of prophylactic treatments. Typically, such treatments are not available.

2. Criteria must be set to identify optimal conditions for testing. For example, all agencies planning to conduct HIV testing must include community review panels. The benefits of testing rely on the provision of adequate follow-up and prophylactic care. There is a question of whether youth with a history of suicidality or conduct disorder should be tested and what should be the context for delivery of pre-test counseling.

III. Prevention Research

A. What types of programs successfully provide preventive and intervention services; how long and in what contexts will the programs maintain success?

1. For HIV positive youth, it will be necessary to identify youths in need of clinical services.

2. HIV must be considered within the context of comprehensive primary health care and social services for youth. Comprehensive services address the health care and services necessary for healthy development from a holistic approach. The term comprehensive care does not imply a singular response to health care, but rather refers to an integrated provision of services for the youth's spiritual, physical, intellectual, familial, and relationship needs. To provide such services, it is necessary to identify optimal design of adolescent health centers, staffing patterns (e.g., when should peer counselors be used and when should they not), resources, philosophy, and degree of integration needed across services.

3. Culturally specific methods of designing and delivering preventive services must be developed in each country. Innovation will occur when the methods used to problem solve difficult questions in one country can be applied to others in a different context.

IV. Evaluation

A. How does the process of gathering data contribute to the integrity of the information obtained? What organizations and services are needed to effectively gather, communicate, and disseminate information about street youth?

1. It will be necessary to differentiate clinical and research contexts and differing responsibilities in terms of informed consent, confidentiality, and the design of interventions.

2. Research is always embedded in community contexts and must include attention to the following issues:

a. Youth are participants, not subjects.
b. Respect youth as collaborative experts.
c. Involve multidisciplinary research teams to enrich our understanding of youth's issues.
d. Identify underlying theoretical assumptions that lead the research to pose research questions in a discriminatory manner against youth.
e. Recognize that our own attitudes may be instruments of social control
f. Assessments must rely on non-judgmental interventions and non-homophobic interviewers.
g. Adopt realistic versus moralistic stances.
h. Recognize the strengths in youth as well as the deficits.
i. Define behaviors as functional rather than pathological.
j. Be sensitive to local conditions in various cultural and subcultural contexts (e.g. healthy sexuality versus practicing safer sex.)
k. Identify the context of sexual and substance abuse acts.
l. Present data in a non-stigmatizing manner; eg. risk groups versus risk acts.
m. The researcher has a responsibility to advocate, as well as investigate.
n. Promote solidarity among street youth as a group;

3. There is a strong need for a clearinghouse on research on street youth internationally. In addition to findings from research studies, it is important to plan to replicate model programs by developing training manuals, process evaluations, setting clear selection criteria for youth into programs.

4. The non-homeless are a primary target for dissemination of results of studies and programs.

FIRST INTERNATIONAL INVITATIONAL CONFERENCE

ON AIDS AND HOMELESS YOUTH

The Social and Educational Agenda

Prepared by Peter Dalglish, Executive Director, Street Kids International, Toronto, Canada.

The challenge faced by the Conference section focusing on social and education issues was the broad range of issues that were considered relevant and important, from methods of health promotion in the streets to legal and ethical issues affecting homeless children.

The group benefitted from the depth of experience of all of those who were part of the section, and in particular from the participation of the only street child at the Conference.

The session began by asking how street workers and health promoters concerned about the issue of AIDS and homeless youth can target street children without further stigmatizing them. Indeed, even by holding a conference focusing on AIDS and street youth we could be creating an undesirable link in the public eye between street children and AIDS. The population with which we work is among the most marginalized anywhere; we must avoid contributing to their separation from society.

Participants in the section on social and educational issues stated that with respect to targeting our messages we must be both culture-specific and gender-specific. Furthermore, in designing programming we must be aware of the literacy level of the youth we are working with. We must listen to the kids, avoiding preaching middle-class messages. The culture of the street was important. We need more information about the groups that we are working with.

We had to be careful in the choice of words we use to describe street children so as to avoid further stigmatizing them. As an example, describing any street child as a prostitute is pejorative and misleading. Labels are culturally-specific. For example, young Brazilian males who have sex with each other don't see themselves as homosexuals.

The issue of risk perception and street children is complex, and contradictions are apparent. It was stated by one member of the section that street children have relatively few sexual partners, and that the perception by many that street children are promiscuous is false. At the same time it was agreed that adolescence was a time of sexual experimentation, and that in this respect street children are the same as other kids. Furthermore, it was recognized that lacking the support of parents, schools, churches, mosques and other institutions, street children rely more heavily on each other for comfort and affection than middle-class children of the same age.

Street children are like all youth in that they consider themselves to be invulnerable, and even immortal. We should ask the kids what activities they consider to be risky. What does "high risk activity" mean to them, and to the street workers? Risk is always relative, and must be examined in context. We should look at the whole person, and his/her range of needs. For a hungry 10 year-old in prison can there be any perceived risk from the danger of contracting AIDS? For most street youth AIDS is yet another hazard that must be contended with, just like the police, abusive adults, weapons, and large dogs.

With respect to the use of fear, what is most effective is to show street children how they can be in control of the situation - how they can limit their risk of exposure to AIDS. Risk should be personalized for it to have any impact. Putting out fear messages with no explanation of how to limit the danger of AIDS will be ineffective. In any case, anxiety can only be created in people with a certain amount of self-esteem.

Testing of street children for HIV is problematic, and raises fundamental ethical issues. Why should projects agree to HIV prevalence studies among street youth when few if any treatment or counselling services are available to those who test positive? Are studies being carried out for the benefit of the children, or for the benefit of the researchers and their institutions?

Testing of street children for HIV can only be supported when it is voluntary, informed and anonymous. To test when these conditions are not met is a violation of basic human rights. In Brazil street children have been tested for HIV without their knowledge; this must be condemned. A real danger exists that prevalence statistics will be misused by unscrupulous journalists and public authorities, and street children will be stigmatized as a result. The situation in each country and community will vary, and cultural issues should be taken into consideration.

Organizations working with street children must attempt to make the best use of limited resources. AIDS should therefore be approached in the context of limiting the spread of all STD's. Different techniques should be used in an attempt to reach as many kids as possible; no one method will suffice. T-shirts, games, street theater, comic books, puzzles, magazines and puppets are all useful.

Some of the most innovative AIDS health promotion involves using kids as educators. This has been pioneered in Brazil by the National Movement for Street Children, and by the Street Educators' Training Centre. "Junior educators" take the message to the streets about what AIDS is, how it is transmitted, and how to protect oneself.

The youths who serve as educators gain self-esteem, and may well become the street workers of the future. A first step is to make street children aware that they can become effective educators.

Training of street workers about AIDS is essential. Again, Brazil and the Street Educators' Training Centre is showing us the way, and can serve as an example for other countries - including countries belonging to the developed world. Projects working with gay-identified youth should have gay-identified street workers in their employ. Street workers should be taught to deal with their own sexuality, prejudices and presumptions.

As a rule we should make good use of existing children's organizations and networks. Some groups may be uncomfortable with the issue of AIDS, so they must be carefully won over. Everyone can play a role. As a Jonathan Mann, the former head of the WHO Global Programme on AIDS often said, "AIDS is everyone's business."

We all must do a better job of talking with each other, and with youth, about sex. Street workers report that youth who are sexually active often know little about sex, and human reproduction. Girls and young women have long been overlooked by many organizations active with poor youth; many projects for street children are run by men, and reflect their bias. We should use AIDS as an opportunity to talk about sexuality, and about caring for other human beings.

AIDS requires political action, and the American group ACT UP is a good model for groups working with street children. Mass political action, strategically planned, can attract the attention of decision makers - and can incur their wrath. Each situation must be dealt with locally. In the Philippines community action helped to limit the problem of sexual abuse of children at Pagsanjan by foreigners. Parents decided to expose those officials and local businesses that were benefitting from sex tourism.

In many countries churches are the traditional service-providing institution for street children. Unfortunately the Catholic Church has been slow to move on the issue of AIDS, and has yet to deal honestly with issues involving sexuality. Covenant House in Toronto, the city's largest agency working with street youth, will not distribute or promote condoms.

Although condoms are the most effective means of preventing the transmission of the AIDS virus, they still are not popular among street youth. In many places they are not available, or are not affordable. They may be too large for young adolescent males. Street youth must be instructed in their proper use, and disposal.

Prisons represent a worst case scenario with respect to the issue of street children and AIDS. Children are regularly abused by guards, and comfort sex among youth inside the institutions is common. Most prisons are overcrowded. Condoms are rarely made available. In Lima street children in institutions are being tested against their will. Approximately 3500 youth are in reformatories; the average detention time is 2 - 3 months.

Our emphasis must be on educating officials about the danger of keeping children and youth in institutions. Why should any kid be in jail? Direct action is needed, and groups like Amnesty International can play an important role.

We should get professionals involved, including lawyers. We cannot tolerate egregious violations of the basic rights of children - rights which are now codified in the Convention on the Rights of the Child.

Suggestions that children and youth who are HIV positive should be isolated in special residences must be resisted. The emphasis should be on prevention and education, not segregation.

Comments by the one street youth who attended the conference were sobering. Byron Gomez from Guatemala reminded us that most street children don't listen to any adults, and that street children are regularly refused treatment in publicly-funded clinics and hospitals.